



# OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT

Complete this form **ONLY** if your accident is reportable under Oregon Law. The accident is reportable if it happened on a highway or premises open to the public, and resulted in **any** of the following: 1) More than \$1000 in damage to any one person's property; 2) Injury to any person (no matter how minor the injury); or, 3) the death of any person. **(PLEASE PRINT)**

LOCATION & TIME

ACCIDENT DATE	DAY OF WEEK M T W TH F S SN	TIME OF DAY AM PM	COUNTY	<b>DO NOT WRITE IN THIS SPACE</b>	Accident Number _____
ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route)			MILE POST		Accident Type Code (Circle One) <b>1 2 3 4 6 8 9 X R P</b>
<input type="checkbox"/> WITHIN _____ FEET N S E W NAME OF NEAREST INTERSECTING ROAD <input type="checkbox"/> NEAR _____ MILES N S E W				<input type="checkbox"/> WITHIN _____ FEET N S E W NAME OF NEAREST CITY / TOWN <input type="checkbox"/> NEAR _____ MILES N S E W	

YOUR INFORMATION

**TYPE OF ACCIDENT** - The accident involved one or more of the following: (Mark all that apply):

<input type="checkbox"/> Two vehicles	<input type="checkbox"/> Fatality	<input type="checkbox"/> ATV / Snowmobile	<input type="checkbox"/> Train	<input type="checkbox"/> Animal _____
<input type="checkbox"/> More than two vehicles	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Parked vehicle	<input type="checkbox"/> Fixed object _____
	<input type="checkbox"/> Pedestrian		<input type="checkbox"/> Overtaken vehicle	<input type="checkbox"/> Other _____

Were you covered by liability insurance at the time of the accident? ☐ YES ☐ NO If you do not complete ALL of this section, your accident will be considered uninsured and your driving privileges may be suspended. You must list the insurance company that provided liability coverage for the vehicle you were driving. DMV will verify this information with the insurance company. If the insurance company denies the coverage, DMV will suspend your Oregon driving privileges.

DRIVER'S NAME (LAST, FIRST, MIDDLE)		DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX
DRIVER'S ADDRESS		CITY	STATE	ZIP CODE	<input type="checkbox"/> IF ADDRESS CHANGE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME		CITY	STATE	ZIP CODE	
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS		CITY	STATE	ZIP CODE	
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

OTHER DRIVER

Was your vehicle's damage: ☐ more than \$1000 or ☐ \$1000 or less?

Did the accident occur while you were driving your employer's vehicle? ..... ☐ YES ☐ NO

Were you driving on your job and being paid for the principal purpose of driving? ..... ☐ YES ☐ NO

Were you being paid to drive and/or deliver persons or property? ..... ☐ YES ☐ NO

Were you operating a government owned vehicle marked for transporting mail in accordance with government rules? ..... ☐ YES ☐ NO

Were you operating an authorized emergency vehicle? ..... ☐ YES ☐ NO

Were you operating a commercial motor vehicle requiring you to have a commercial driver license? ..... ☐ YES ☐ NO

a) Were you transporting hazardous material? ..... ☐ YES ☐ NO

DRIVER'S NAME (LAST, FIRST, MIDDLE)		DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX
DRIVER'S ADDRESS		CITY	STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME		CITY	STATE	ZIP CODE	
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS					
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

NARRATIVE

IF ADDITIONAL VEHICLES WERE INVOLVED IN THE ACCIDENT, ATTACH A SUPPLEMENTAL REPORT.

**DESCRIBE WHAT HAPPENED:**


SIGNATURE

I certify all information given on this report is true and accurate to the best of my knowledge.

SIGNATURE OF PERSON MAKING REPORT <b>X</b>	DATE SIGNED
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